

REQUEST FOR REIMBURSEMENT

Saw an out-of-network doctor? We are here to help. If you have out-of-network benefits, these are your options:

Online

By Mail

OR

It's the way to go. It's secure, you can check on claim status, get paid faster, and save on paper. Click the button below or go to www.vsp.com to log into your account and complete an Internet form. You can also create an account there if you don't have one yet.

Still want to mail the form in? Follow the form instructions on the next page.




I want to get paid faster

Tips to speed claims processing:

Missing or incomplete information will slow down claims processing. Be reimbursement ready by making sure the following are done:

- Copy of itemized receipts or service statements that contain the following:
 - Doctor's name or office name
 - Name of patient ○ Date of service
 - Each service received and the amount paid
- You typically have 12 months from the date of service to submit for reimbursement.
- Make sure all required fields have a value and dates are in the following format: Month/Day/Four-Digit Year.
- If you have Laser Vision coverage and are submitting for reimbursement:
 - The itemized receipt and/or letter from your provider must contain the following information:
 - Which eye(s) received the surgery
 - Surgeon Name
 - Facility Name
 - Surgery DOS
 - Type of procedure (e.g. PRK, LASIK, Custom LASIK and Custom PRK)
 - Cost of procedure
 - Member's name
 - Member's ID number (This may be the member's SSN or member's unique ID number)
 - Member's mailing address
 - Patient's name
 - Patient's DOB
 - Patient's relationship to the member (e.g. member, spouse, child, etc.)
 - Name of client who provides the VSP coverage (client name)
 - Please note: Laser Vision warranty enhancements are not reimbursable under Laser Vision Care out-of-network. Claims may only be submitted for surgery (one or both eyes) and/or pre/post-operative care.
 - Write the amount of the Laser Vision Care claim under "Exam" on the reimbursement form.

Why stay in-network next time? Here are some benefits to staying in-network:

-  **SAVE MONEY.** Get the coverage you deserve at low out-of-pocket costs.
-  **SAVE TIME.** With more than 37,000 in-network doctors to choose from, it's easy to find one who's conveniently located near your work or home.
-  **SAVE THE HASSLE.** There are no claim forms to fill out when you see an in-network doctor. Your VSP network doctor and VSP will take care of it for you.

FORM INSTRUCTIONS

The form must be filled out by the member. All fields flagged with an asterisk (*) are required. The form is fillable, so you do not have to hand write. Fill it out on a computer, print it, and mail it in. If you decide to hand write, use blue or black ink.

Patient section:

1. Select the patient's relation to the member. Choose only one.
2. Enter the patient's date of birth in the following format: Month/Day/Four-Digit Year
3. Select a gender. Choose only one.
4. Enter the patient's last name and first name.
5. Enter the address, city, state and ZIP code.
6. The patient's middle initial and ZIP+4 are optional.

Member section:

1. Enter the Last 4 Digits of the member's SSN or unique ID number.
2. If the patient is the member, select "Member information below is the same as Patient." 3. Otherwise, enter the member's information:
 - a. Enter the member's date of birth in the following format: Month/Day/Four-Digit Year
 - b. Select a gender. Choose only one.
 - c. Enter the member's last name and first name.
 - d. Enter the first address line, city, state, and ZIP code.
 - e. The member's middle initial, second address line, and ZIP+4 are optional.

Claim section:

1. Enter the Date of Service in the following format: Month/Day/4-Digit Year.
2. Enter the amount charged for each applicable line item. Ensure they match the receipts.
3. Select a Lens Type.
4. If another insurance company is involved, check the box and attach a copy of the statement showing payment.

Provider section:

1. If the provider's name is known, enter the provider's last name and first name.
2. If the office name is known, enter the provider's office name.
3. Step #1 or #2 or both must contain a value.
4. Enter the first address line, city, state, and ZIP code.
5. The second address line and ZIP+4 are optional.

Print and Sign section:

1. Review the completed form for accuracy.
2. Read the acknowledgement paragraph.
3. Print the form.
4. Sign the form.
5. Date the form in the following format: Month/Day/Four-Digit Year.
6. Only the form on the next page needs to be mailed in. All other pages are for reference.

VSP MEMBER REIMBURSEMENT FORM

To request reimbursement, complete and print this form, enclose a legible copy of your itemized receipt(s), and send them to the following address. Be sure to keep a copy for your records.

VSP
PO Box 495918
Cincinnati, OH 45249-5918

PATIENT	Relation to Member*: (choose one)							
	<input type="radio"/> Member		<input type="radio"/> Domestic Partner		<input type="radio"/> Dependent Parent		<input type="radio"/> Disabled Dependent	
	<input type="radio"/> Spouse		<input type="radio"/> Child		<input type="radio"/> Full-Time Student		<input type="radio"/> Other	
	Date of Birth*: (mm/dd/yyyy)				Gender*: <input type="radio"/> Male <input type="radio"/> Female			
	Last Name*:			First Name*:			MI:	
Address*:								
City*:			State*:		ZIP Code*:		ZIP+4:	

MEMBER	Last 4 Digits of SSN*:							
	<input type="checkbox"/> Member information below is the same as Patient							
	Date of Birth*: (mm/dd/yyyy)				Gender*: <input type="radio"/> Male <input type="radio"/> Female			
	Last Name*:			First Name*:			MI:	
	Address 1*:			Address 2:				
	City*:			State*:		ZIP Code*:		ZIP+4:

CLAIM	Date of Service*: (mm/dd/yyyy)		<input type="checkbox"/> Another insurance company made payments to you, another insurer, or the doctor's office. If so, attach a copy of the statement showing payment.					
	Exam.....		\$	Lens Type*: (choose one)				
	Frame.....		\$	<input type="radio"/> Single		<input type="radio"/> Progressive		
	Lens.....		\$	<input type="radio"/> Bi-focal		<input type="radio"/> Lenticular		
	Lens tints or coatings.....		\$	<input type="radio"/> Tri-focal				
	Contact Lens Exam / Fitting Evaluation.....		\$					
	Contacts.....		\$					

PROVIDER	Last Name:			First Name:				
	Office Name:							
	Address 1*:				Address 2:			
	City*:			State*:		ZIP Code*:		ZIP+4:

PRINT & SIGN	I acknowledge that the above-named provider is not a VSP Preferred Provider and that VSP cannot guarantee eye care and/or eyewear satisfaction. By signing this claim form, I certify that I have read the applicable claim fraud warnings included with this form, and that all the information I have provided above is complete and accurate.							
	Claimant Signature: _____						Date: _____	

FRAUD WARNINGS

Alabama, Arkansas, District of Columbia, Louisiana, Massachusetts, Minnesota, New Mexico, Ohio, Rhode Island and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

Arizona: For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California: For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly presents false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Delaware, Idaho, Indiana and Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive an insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Florida: A person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine, Tennessee, Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud as provided in RSA 638:20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Oregon: Any person who knowingly presents a materially false statement of claim may be guilty of a criminal offense and may be subject to penalties under state law.

Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars (\$5,000), not to exceed ten thousand dollars (\$10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Texas: Any person who knowingly presents a false or fraudulent claim for penalty of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Vermont: Any person who knowingly presents a false statement of claim for insurance may be guilty of a criminal offense and subject to penalties under state law.

Pennsylvania and all other states: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Punjabi: ਧਿਆਨ ਧਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਧਿਓਂਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ

ਉਪਲਬਧ ਹੈ। 1-800-8777195 (TTY: 1-800-428-4833) 'ਤੇ ਕਾਲ ਕਰੋ।

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-877-7195 (TTY: 1-800-428-4833).

Amharic: ማሰታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-877-7195 (መስማት ለተሳናቸው: 1-800-428-4833).

Ukrainian: УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-877-7195 (телетайп: 1-800-428-4833).

Nepali: ध्यान दिनहोसु : तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको दैनिकीत भाषा सहायता सेवाहरू दनि:शल्कु रूपमा उपलब्ध छ । फोन गनहोसु 1-800-877-7195 (दिदिवाई: 1-800-428-4833)

Romanian: ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-877-7195 (TTY: 1-800-428-4833).

Sudan (Fulfulde): MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-800-877-7195 (TTY: 1-800-428-4833).

Thai: เรียน: ถาคุณพูดภาษาไทยคุณสามารถไ้ขอรับการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-877-7195 (TTY: 1-800-428-4833).

Laotian: ໂປດຊາບ: ຖາວາ ທານເວາພາສາ ລາວ, ການບລການຊ່ອຍເຫຼອດານພາສາ, ໂດຍບເສຍຄ່າ, ແມນມພອມໄທທານ. ໂທ 1-800-877-7195 (TTY: 1-800-428-4833).

Cushite/Oromo: XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-877-7195 (TTY: 1-800-428-4833).

Persian (Farsi):

مهارف شما (يارب نايفگار ترو بصر زبانی ستهيتلا، دينک يم گفتگو يسراف نازب هب اکر : هجوت اب . دشاب يم 1-800-877-7195 (TTY: -4833-428-800) 1دير يگب سامت .

Arabic:

مقر 1-800-877-7195 (TTY: 1-800-428-4833) 5917-778-008 مقرب لصات . اجمالين لك رفاوتت يتوغللا قدلاماسع تامدخ إفن ،ةغللا ذاکر ثدحتت تنک اذا .: 008-824-3384-1 مصلأ فتاه: 008-824-3384-1

Navajo

Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éí ná hóló, koji' hódííłnih 1-800-877-7195 (TTY: 1-800-428-4833.)

हिंदी (Hindi)

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-877-7195 (TTY: 1-800-428-4833) पर कॉल करें।